STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G559	A. BUILDING 00 B. WING	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	2901 BEVERLY DR GARY, IN 46408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a fundamental recertification and state licensure survey. Dates of survey: February 13, 14, 15, and 16, 2012. Provider Number: 15G559 Facility Number: 001073 AIM Number: 100239890 Surveyor: Tim Shebel, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/23/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement their abuse/neglect policy to show evidence of a thorough investigation of 1 of 1 injury of unknown origin which involved 1 of 2 sampled clients living at the group home (client #2). Findings include: 1. The facility's incident reports, from 8/1/11 to 2/13/12, were reviewed on 2/13/12 at 1:42 P.M.. The review indicated the following injury of unknown origin involving client #2: "Date of Incident/Accident: 1/19/2012, Name: [Client #2], What happened? On the way to take [client #2] to bus [workshop staff #1] noticed scratch on [client #2's] right pinky finger. Cause of Incident/Accident? [Client #2] scratched herself on right pinky finger." Further review of the 1/19/12 incident report failed to indicate the cause of client #2's injury and if the cause of the injury was investigated. Workshop supervisory staff #3 was interviewed on 2/16/12 at 11:52 A.M..	W0149	Upon further review the policy and procedure for abuse and neglect is in place, per the company. However staff who originally reported to the immediate supervisor did not make management aware that it was assumed that the injury occurred by scratch. Staff in error will be retrained for further preventive measures. All staff at the center will be retrained in the following areas: completing incident and accident reports; review of investigation process; review of unknown screening tool to access unknown injuries. To ensure future compliance residential management and day service management will monitor all incident reports and investigations. Any uncertainties will be further reviewed.	03/17/2012

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	Workshop supervisory staff #3 stated workshop staff #1 did not witness how client #2's finger was scratched but "assumed she (client #2) scratched herself." Workshop supervisory staff #3 further stated the cause of client #2's injury "should have been investigated instead of assuming she (client #2) scratched herself." The facility's records were further reviewed on 2/16/12 at 2:02 P.M.. Review of the facility's "Policy for Handling Cases of Neglect and Abuse", dated 12/20/2006, indicated, in part, the following: "III. All allegations will be investigated per the facility's investigation process." 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W0154	See tag 149 page 1	03/17/2012

Based on record review and interview, the facility failed to show evidence of a thorough investigation of 1 of 1 injury of unknown origin which involved 1 of 2 sampled clients living at the group home (client #2).

Findings include:

1. The facility's incident reports, from 8/1/11 to 2/13/12, were reviewed on 2/13/12 at 1:42 P.M.. The review indicated the following injury of unknown origin involving client #2: "Date of Incident/Accident: 1/19/2012, Name: [Client #2], What happened? On the way to take [client #2] to bus [workshop staff #1] noticed scratch on [client #2's] right pinky finger. Cause of Incident/Accident? [Client #2] scratched herself on right pinky finger." Further review of the 1/19/12 incident report failed to indicate the cause of client #2's injury and if the cause of the injury was investigated.

Workshop supervisory staff #3 was interviewed on 2/16/12 at 11:52 A.M.. Workshop supervisory staff #3 stated workshop staff #1 did not witness how

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	client #2's finger was scratched but "assumed she (client #2) scratched herself." Workshop supervisory staff #3 further stated the cause of client #2's injury "should have been investigated instead of assuming she (client #2) scratched herself." 9-3-2(a)			

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review, and interview, the facility failed for 1 of 2 sampled clients (client #1) to ensure the Service Coordinator (Qualified Mental Retardation Professional) incorporated client #1's communication cards into the client's Individual Program Plan at the workshop. Findings include: Client #1 was observed at the facility owned workshop on 2/13/12 from 2:45 P.M. until 4:00 P.M.. Workshop staff #1 and #2 were observed to periodically interact with client #1 and assist the client in sorting letters of the alphabet. Workshop staff #1 and #2 were not observed to assist the client in utilizing communication cards. Workshop staff #1 and #2 were interviewed on 2/13/12 at 3:49 P.M.. Workshop staff #1 and #2 stated client #1 did not have any communication cards at the workshop "that we are aware of." Client #1's records were reviewed on 2/13/12 at 8:56 A.M.. Review of the	W0159	Service Coordinator will train DSPs at day services on using and implementing Client #1's communication cards. To ensure future compliance, Service Coordinator will monitor twice monthly for three months and monthly thereafter.	03/17/2012

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	client's 12/14/11 Individual Program Plan indicated the client had communication cards which staff were to use to assist the client in indicating "happy, sad, yes, no, music, eat, drink." Service Coordinator #1 was interviewed on 2/16/12 at 10:10 A.M.. Service Coordinator #1 indicated client #1's communication cards were utilized at the group home and were to be used at the workshop also. Service Coordinator #1 stated, "A set of [client #1's] communication cards was sent to the workshop and staff were trained on their usage. Staff at the workshop sometimes move from one group room to the next and probably do not always know where [client #1's] communication cards are." 9-3-3(a)			

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W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, the facility failed for 1 of 2 sampled clients (client #1) to ensure client #1's Individual Support Plan (ISP) had a training program in place to address client #1's drooling. Findings include: Client #1 was observed at the facility owned workshop on 2/13/12 from 2:45 P.M. until 4:00 P.M.. During the observation period, client #1 was observed to drool onto her sweatshirt. The chest area of her sweatshirt was saturated with saliva. Workshop staff #1 and #2 interacted with client #1 but did not assist the client in wiping her mouth, providing a shirt protector, or securing a clean and dry shirt. Client #1's record was reviewed on 2/16/12 at 8:56 A.M.. Review of client #1's 12/14/11 Individual Program Plan failed to indicate a program to address client #1's drooling.	W0227	Client #1's team will evaluate and decide on the best method to address her drooling. Once developed staff will be trained on plan. To ensure future compliance, Service Coordinator will monitor weekly for three months and bi-weekly thereafter.	03/17/2012

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	Service Coordinator #1 was interviewed on 2/16/12 at 10:10 A.M.. Service Coordinator #1 indicated client #1 did not have a program to address the client's drooling. 9-3-4(a)			

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W0323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed to have 2 of 2 sampled client's (client #1 and 2's) vision screened, within one calendar year. Findings include: Client #1's record was reviewed on 2/16/12 at 8:56 A.M.. The review indicated client #1's last vision screening was conducted on 5/23/10. Client #2's record was reviewed on 2/16/12 at 9:33 A.M.. The review indicated client #2's last vision screening was conducted on 6/21/10. Nurse #1 was interviewed on 2/16/12 at 10:20 A.M.. Nurse #1 indicated client #1's most current vision screening was conducted on 5/23/10 and client #2's most current vision screening was conducted on 6/21/10. 9-3-6(a)	W0323	Client # 2 is scheduled for a vision screening on 3/30/2012. Client #1 is scheduled for a vision screening on 3/30/2012. To ensure future compliance medical screenings will be reviewed during the annual IDT to assure they have been completed timely.	03/17/2012

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation and interview, the facility failed to assure 1 of 2 clients requiring a wheel chair (client #2) had a wheel chair which was in good repair. Findings include: Client #2 was observed at the workshop on 2/13/12 from 2:45 P.M. until 4:00 P.M., at the group home on 2/13/12 from 4:03 P.M. until 6:00 P.M., and on 2/14/12 from 6:00 A.M. until 7:45 A.M.. During the observations, client #2 was seated in a wheel chair. The wheel chair had a broken left foot rest. Service Coordinator #1 was interviewed on 2/16/12 at 10:10 A.M.. Service Coordinator #1 indicated client #1's wheel chair had been broken several times during the past year and the facility is in the process of securing physician and Medicaid approval so a new wheel chair can be purchased for client #2. Service Coordinator #1 further indicated the	W0436	Due to client #2 physical spasticity, she frequently stresses the left foot pedal. The Service Coordinator is monitoring the replacement of her chair weekly. To ensure future compliance, we have secured a full wheelchair assessment. The Service Coordinator will continue to monitor the progress weekly until new chair arrives.	03/17/2012

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	facility's maintenance department would repair the foot rest on client #2's wheel chair until a new wheel chair was purchased. 9-3-7(a)			